VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

Patient's Name (Last, First, Middle Initial)	Mother's Maiden Name (Last, First, Middle Initial)

Address (Street/Road/POBox)	Home Telephone Number ( )

City	County	State	Zip Code	Work Telephone Number ( )

Social Security Number	Date of Birth (mm/dd/yyyy)	Gender	Ethnicity (Check one)
		☐ Male ☐ Female	☐ Hispanic ☐ Non-Hispanic

Race (Check one) ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Other

Eligibility Status (Check all that apply) This section must be completed.
☐ **Native American** ☐ **Badger Care** ☐ **Insured, Vaccines Covered**
☐ **Medicaid Eligible** ☐ **No Health Insurance** ☐ **Insured, Vaccines Not Covered**

Name of Physician	Name of Insurance Provider	Name of School or Day Care (if applicable)

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	Relationship to Patient

Okay to share immunization data with WIR?	Is reminder or recall contact allowed?	Would you like reminder/recall sent to you?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf.	Date Signed

FOR OFFICE USE

* RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Subcutaneous injections are administered in the muscle "area".

Vaccine	Route	Site Admin*	Dose Number	Manufacturer	Lot Number	Exp Date	CDC Form Date
DTaP / DT	IM	RV LV RD LD	1 2 3 4 5	GSK			05/17/07
DTaP-HepB-IPV Combined (Pediarix)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP,HepB,Polio
Hepatitis A	IM	RV LV RD LD	1 2	GSK			03/21/06
Hepatitis B	IM	RV LV RD LD	1 2 3	GSK			7/18/07
Hib	IM	RV LV RD LD	1 2 3 4	Merck			12/16/98
Hib-Hep B Combined (Comvax)	IM	RV LV RD LD	1 2 3	Merck			Use dates from Hib & Hep B
HPV (Human Papillomavirus)	IM	RV LV RD LD	1 2 3	Merck			02/02/07
Influenza	IM	RV LV RD LD	1 2	SP - Chiron			Use latest VIS
Meningococcal Conjugate (MVC4)	IM	RV LV RD LD	1	SP			1/28/08
MMR	SQ	RV LV RD LD	1 2	Merck			3/13/08
MMR - Varicella	SQ	RV LV RD LD	1	Merck			Use dates from MMR & Varicella
Pneumococcal Conjugate (PCV7) (Prevnar)	IM	RV LV RD LD	1 2 3 4	Wyeth			09/30/02
Polio	IM or SQ	RV LV RD LD	1 2 3 4	SP			01/01/00
Rotavirus	Oral	RV LV RD LD	1 2 3	Merck			08/28/08
Td	IM	RV LV RD LD	1 2 3 4 5	SP - MPHBL			06/10/94
Tdap (Adacel)	IM	RV LV RD LD	1	SP			07/12/06
Varicella	SQ	RV LV RD LD	1 2	Merck			3/13/08
Other		RV LV RD LD					

Signature & Title - Person Administering Vaccine	**Date Vaccine Administered**
Staff Nurse RN BSN	

Screening Questionnaire for Immunizations

FOR PATIENTS / PARENTS / GUARDIANS: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

Don't Know	YES	NO	Fill out form about person receiving shots listed on the other side of this form.
☐	☐	☐	1. Is the person sick today?
☐	☐	☐	2. Does the person have allergies to medications, food, or any vaccine?
☐	☐	☐	3. Has the person had a serious reaction to a vaccine in the past?
☐	☐	☐	4. Has the person had a seizure or a brain problem?
☐	☐	☐	5. Does the person have cancer, leukemia, AIDS, or any other immune system problem?
☐	☐	☐	6. Has the person taken cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments in the past 3 months?
☐	☐	☐	7. Has the person received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?
☐	☐	☐	8. Has the person received any vaccinations in the past 4 weeks?
☐	☐	☐	FOR WOMEN ONLY: Is the person pregnant or is there a chance she could become pregnant in the next 3 months?

I acknowledge that I have received a copy of the Grant County Health Department's Notice of Privacy Practice and have been given an opportunity to discuss concerns. I consent to have my protected health information used for treatment, payment and health care operations.

SIGNATURE:_____ Date:_____

(Person to receive vaccine or person authorized to sign on the patient's behalf.)